Schedule of Benefits

The Harvard Pilgrim Independence Plan℠
Massachusetts

Services listed below are covered when Medically Necessary. Please see your Benefit Handbook for details.

Your Plan offers two levels of coverage: In-Network and Out-of-Network.

In-Network Coverage
In-Network coverage applies:

- When you use a Participating Provider for Covered Services
- When you receive care in a Medical Emergency
- When you obtain Covered Services from our affiliated national network of providers when out of the enrollment area. (Please refer to Section A.5 of the Benefit Handbook, "Out-of-Area Covered Services from our affiliated national network of providers", to determine Member Cost that applies to these services.)

One important part of The Independence Plan is that it rewards members for choosing higher quality and more cost efficient specialists. We tiered physicians in specialties that:

- Members use most often, and for which we had the most data to measure
- Show the widest variation in the ways that doctors treat similar conditions
- Represent the most meaningful opportunity for cost savings for Plan Members

Harvard Pilgrim looked at how other health plans across the country tier providers, and incorporated principles agreed upon by local and national stakeholder groups for making fair and appropriate comparisons among physicians.

Harvard Pilgrim has worked with the analytical tools and statistical expertise of industry leaders to "profile" participating providers in twelve high-volume specialties in Massachusetts. The goal of this work was to compare the relative effectiveness of doctors in the same specialty in treating similar patients. Based on these comparisons, specialists were grouped into three levels, known as Tier 1 Providers, Tier 2 Providers and Tier 3 Providers.

Quality of care was evaluated based on clinical guidelines for recommended care. Cost efficiency was evaluated by comparing how much it cost for each specialist to treat Harvard Pilgrim members for similar conditions.

The following page describes how Participating Providers are placed into each of the three tiers.

Out-of-Network Coverage
Out-of-Network coverage applies when you use a Non-Participating Provider for Covered Services.

Please refer to your *Benefit Handbook* for further information about how your In-Network and Out-of-Network coverage works.

Member Cost
Members are required to pay part of the cost of the benefits provided under the Plan. The following is a summary of the Member Cost amounts under your Plan.

Your Plan has different **Copayments** that apply depending on the type of Provider or the type of service. These Copayments are described below.

Office Visit Copayment
When you receive outpatient care from Participating Providers, your care will be covered with a Copayment. The amount of your Copayment will depend upon whether you see a Tier 1 Provider, a Tier 2 Provider or a Tier 3 Provider and what type of service you receive.

In-network care
Tiered providers
The Harvard Pilgrim Independence Plan rewards members with lower office visit copayments for choosing high-quality, cost-efficient Massachusetts specialists. Physicians in the following 12 specialties have been rated on quality and cost-efficiency measures and placed into one of three categories or "tiers."

- Allergy/Immunology
- Cardiology
- Dermatology
- Endocrinology
- Gastroenterology
- General Surgery
- Neurology
- Obstetrics/Gynecology
- Ophthalmology
- Orthopedics
- Otolaryngology (ENT)
- Rheumatology

Specialists' tiers are designated in the provider directory with asterisks. These mean:
*** (Tier 1 – Excellent);
** (Tier 2 – Good); and
*(Tier 3 – Standard)

Tier 1 copayments are the lowest and Tier 3 copayments are the highest. However, certain services, no matter who provides them, have a Tier 1 copayment. These include services such as: routine physicals; outpatient behavioral health services; immunizations; annual gynecological exams; and routine eye exams. Please see page 3 for a complete list.

Non-tiered providers
"Non-tiered" providers include all other Harvard Pilgrim providers who have not been rated for quality and/or cost-efficiency or assigned to a tier. These include:

- All Harvard Pilgrim providers (Massachusetts and other states) in: internal, adolescent and geriatric medicine; family and general practice; pediatrics; physical, speech and occupational therapy; chiropractic; audiology; optometry; and midwives and nurse practitioners. These providers have the same copayment as Tier 1 specialists and are marked in the provider directory with ***.
- Massachusetts physicians in the 12 tiered specialties for whom there was insufficient data to measure. These specialists have the same copayment as Tier 2 specialists and are marked in the provider directory with **.
- Non-Massachusetts physicians in the 12 tiered specialties. These specialists have the same copayment as Tier 2 specialists and are marked in the provider directory with **.
- All other Harvard Pilgrim specialists (Massachusetts and other states) outside of the 12 tiered specialties. These specialists have the same copayment as Tier 2 specialists and are marked in the provider directory with **.

Again, certain services, no matter who provides them, have a Tier 1 copayment. Please see page 3 for a complete list.

Important note about tiered and non-tiered providers: Some providers in tiered specialties such as cardiology, gastroenterology, and obstetrics/gynecology may also be providers in internal medicine, pediatrics or other primary care specialties. For these providers, the copayment for the tiered specialty may apply. For example, if you visit a Tier 2 gastroenterologist who also practices internal medicine, you will pay the Tier 2 copayment for most services.

The following services are also subject to the Tier 1 copayment:

- Routine well physical examinations
- Routine eye examinations
- Annual routine gynecological examinations
- Physical and occupational therapies
- Early Intervention services
- Immunizations, if billed with an office visit
- Infertility treatment using advanced reproductive technologies or therapeutic donor insemination
- Vision and auditory screening for children
- Nutrition counseling and health education
- Voluntary termination of pregnancy
- Voluntary sterilization

Hospital Inpatient Copayment:

- In-Network Medical: $300 per admission up to a maximum of $1,200 per calendar year
- In-Network Mental Health and Substance Abuse Services: $200 per admission up to a maximum of $800 per calendar year
- Out-of-Network Mental Health and Substance Abuse Services: $150 per admission (Out-of-Network inpatient mental health and substance abuse care is also subject to Deductible and Coinsurance)

If you are readmitted to an in-network acute care hospital or behavioral health hospital within 30 calendar days of a discharge, your second Inpatient Copayment will be waived. Readmittance does not have to be to the same hospital or for the same condition. For example, if you were admitted to a hospital on February 2nd and discharged on February 5th you would pay your Inpatient Copayment. If on February 20th you were readmitted to a hospital, your Inpatient Copayment will be waived. However, if you are readmitted to the hospital on March 7th, you are responsible for paying your Inpatient Copayment. This waiver is limited to a calendar year basis. For example, if you were discharged from a hospital on December 16th, you would pay your Inpatient Copayment. If you are readmitted to a hospital on January 4th, you would be responsible for your Inpatient Copayment, since it occurs in a new calendar year. **Please note: When you are billed for an Inpatient Copayment that should be waived, you must notify Harvard Pilgrim's Member Services Department so that we may adjust your claims.**

Surgical Day Care Copayment

- In-Network Surgical Day Care: $100 per admission up to a maximum of $400 per calendar year

Emergency Room Copayment

- $50 per visit (waived if admitted directly to the hospital from the emergency room, in which case the Hospital Inpatient Copayment applies)

Deductibles:

- You have an **Out-of-Network Deductible** for medical care of $150 per individual contract or $300 per family contract, per calendar year, applied to the reasonable charge
- You have an **Out-of-Network Deductible** for mental health and substance abuse services of $150 per individual contract or $300 per family contract, per calendar year, applied to the reasonable charge

The Out-of-Network Deductible for medical care is separate from the Out-of-Network Deductible for mental health and substance abuse services. These Deductibles do not count towards each other.

Any Deductible amount incurred for services rendered during the last three months of a calendar year will be applied to the Deductible requirement for the next calendar year.

Coinsurance:

- You have **In-Network Coinsurance** of:
  - 20% of the Reasonable Charge for skilled nursing facility care; and
  - 10% of the Reasonable Charge for Coronary Artery Disease programs
- You have Out-of-Network Coinsurance for medical care of 20% of the Reasonable Charge after the Deductible is met until the Out-of-Pocket Maximum is reached
- You have Out-of-Network Coinsurance for mental health and substance abuse services of 20% of the Reasonable Charge after the $150 Copayment and after the mental health Deductible is met until the Out-of-Pocket Maximum is reached
- Out-of-Network, the Member is responsible for any charges in excess of the reasonable charge.

Out-of-Pocket Maximums:

- You have an **In-Network Out-of-Pocket Maximum** for mental health and substance abuse services of $1,000 per individual contract and $2,000 per family contract per calendar year
- You have an **Out-of-Network Out-of-Pocket Maximum** for medical care (excluding Coinsurance for skilled nursing facility care) of $3,000 per Member per calendar year
- You have an **Out-of-Network Out-of-Pocket Maximum** for mental health and substance abuse services of $3,000 per Member per calendar year

Prescription Drug Copayments and Benefit Reductions do not count towards the Out-of-Pocket Maximums.

Copayment amounts and any charges in excess of the Reasonable Charge do not apply to the Out-of-Network Out-of-Pocket Maximum. Deductible amounts and Coinsurance do apply to the Out-of-Network Out-of-Pocket Maximums.

The Out-of-Pocket Maximum for medical care is separate from the Out-of-Pocket Maximum for mental health and substance abuse services. These Out-of-Pocket Maximums do not count towards each other.

Benefit Reductions:

Your Out-of-Network benefits will be reduced by the amounts listed below, prior to the Plan paying for any Covered Charges:

- Medical: $500 when the required Prior Plan Approval or Notification is not satisfied
- Mental health and substance abuse services: $200 when the required Prior Plan Approval is not satisfied

Benefit Limits

You have one set of Covered Services under the Plan. If a benefit limit applies (such as a day, visit or dollar limit), HPHC calculates your utilization for that benefit based on the Covered Services you have received from both In-Network (Participating Providers) and Out-of-Network (Non-Participating Providers.).

This table is a summary of the Covered Services covered under your Plan. It also indicates the portion of the cost of the benefits that you are required to pay, such as Copayment, Deductible or Coinsurance amounts. More detailed information about the Covered Services under this Plan can be found in the Benefit Handbook.

Service	Member Cost	
	In-Network (Participating Providers)	Out-of-Network (Non-Participating Providers)
Inpatient Acute Hospital Services		
All covered services including the following: ▪ Coronary care ▪ Hospital services ▪ Intensive care ▪ Physicians' and surgeons' services including consultations ▪ Private Duty Nursing ▪ Semi-private room and board (private room is covered when Medically Necessary)	$300 Copayment per admission.	20% of the Reasonable Charge* after the Deductible has been met.
Surgical Day Care Services		
▪ Anesthesia Services ▪ Endoscopic procedures (unless performed in the Hospital Outpatient Department) ▪ Hospital services ▪ Physicians' and surgeons' services	$100 Copayment per admission.	20% of the Reasonable Charge* after the Deductible has been met.
Hospital Outpatient Department Services		
All covered services including the following: ▪ Anesthesia services ▪ Chemotherapy ▪ Endoscopic procedures (unless performed as Surgical Day Care) ▪ Laboratory tests and x-rays ▪ Radiation therapy	No Member Cost.	20% of the Reasonable Charge* after the Deductible has been met.
Skilled Nursing Facility Care Services		
▪ Room and board, special services and physician services up to 45 days per calendar year	20% of the Reasonable Charge*.	20% of the Reasonable Charge* after the Deductible has been met.

*The definition of Reasonable Charge is included at the end of this table.

Service	Member Cost	
	In-Network (Participating Providers)	Out-of-Network (Non-Participating Providers)
Inpatient Rehabilitation Services		
▪ Room and board, special services and physician services	No Member Cost.	20% of the Reasonable Charge* after the Deductible has been met.
Maternity Services		
▪ Prenatal and postpartum care ▪ All hospital services for mother and routine nursery charges for newborn	No Member Cost. $300 Copayment per Admission.	20% of the Reasonable Charge* after the Deductible has been met.
Emergency Room Care Services		
▪ Hospital emergency room treatment You are always covered in a Medical Emergency. In a Medical Emergency, you should go to the nearest emergency facility or call 911 or other local emergency number. If you are hospitalized, you must call HPHC within 48 hours or as soon as you can.	$50 Copayment per visit. This Copayment is waived if admitted directly to the hospital from the emergency room, in which case the Hospital Inpatient Copayment applies for Inpatient Acute Hospital Services.	
Emergency Admission Services		
▪ Inpatient services which are required immediately following the rendering of emergency room treatment	$300 Copayment per admission for Inpatient Acute Hospital Services.	

*The definition of Reasonable Charge is included at the end of this table.

Service	Member Cost	
	In-Network (Participating Providers)	Out-of-Network (Non-Participating Providers)
Physician Services		
All covered services including the following: ▪ Bi-annual routine eye exams – covered once every 24 months ▪ Family planning services ▪ Health education ▪ Nutritional counseling (limited to 3 visits for non-diabetes related conditions per calendar year) ▪ Infertility services ▪ Preventive care, including routine physical examinations, immunizations, and routine eye examinations	Tier 1: $15 Copayment per visit.	20% of the Reasonable Charge* after the Deductible has been met.
▪ Administration of injections ▪ Allergy tests and treatments ▪ Changes and removal of casts, dressings or sutures ▪ Chemotherapy ▪ Consultations concerning contraception and hormone replacement therapy ▪ Diabetes self-management, including education and training ▪ Diagnostic screening and tests, including but not limited to mammograms, blood tests, lead screenings and screenings mandated by state law ▪ Medical treatment of temporomandibular joint dysfunction (TMD) ▪ Sick and well office visits ▪ Vision and hearing screening	Tier 1: $15 Copayment per visit. Tier 2: $25 Copayment per visit. Tier 3: $35 Copayment per visit. (Please note: diagnostic tests, mammograms, x-rays and immunizations will be covered in full if billed without an office visit and no other services are provided.)	20% of the Reasonable Charge* after the Deductible has been met.
▪ Administration of allergy injections	No Member Cost.	20% of the Reasonable Charge* after the Deductible has been met.

*The definition of Reasonable Charge is included at the end of this table.

Service	Member Cost	
	In-Network (Participating Providers)	Out-of-Network (Non-Participating Providers)
Mental Health and Substance Abuse Services		
▪ Inpatient mental health services ▪ Inpatient substance abuse services ▪ Inpatient detoxification	$200 Copayment per admission.	$150 Copayment per admission, then 20% of the Reasonable Charge* after the Deductible has been met.
▪ Outpatient mental health and substance abuse services		
Group therapy visits 1 - 15	$10 Copayment per visit.	20% of the Reasonable Charge* after the Deductible has been met.
Group therapy visits 16 and over	$10 Copayment per visit.	50% of the Reasonable Charge* after the Deductible has been met.
Individual therapy visits 1 - 15	$15 Copayment per visit.	20% of the Reasonable Charge* after the Deductible has been met.
Individual therapy visits 16 and over	$15 Copayment per visit.	50% of the Reasonable Charge* after the Deductible has been met.
▪ Intermediate Services, including detoxification, acute residential treatment, crisis stabilization, day/partial hospital programs, 24 hour intermediate care facilities, therapeutic foster care and structured outpatient programs.	No Member Cost.	20% of the Reasonable Charge* after the Deductible has been met.
▪ Psychopharmacological services	$10 Copayment per visit.	
▪ Psychological testing and neuropsychological assessment	No Member Cost.	

*The definition of Reasonable Charge is included at the end of this table.

Service	Member Cost	
	In-Network (Participating Providers)	Out-of-Network (Non-Participating Providers)
Dental Services		
▪ Initial emergency treatment (within 72 hours of injury) ▪ Reduction of fractures and removal of cysts or tumors	$25 Copayment per office visit. $300 Copayment per admission if inpatient services are required. $100 Copayment per admission if Surgical Day Care Services are required.	20% of the Reasonable Charge* after the Deductible has been met.
▪ Removal of 7 or more permanent teeth, excision of radicular cysts involving the roots of three or more teeth, extraction of impacted teeth, and gingivectomies of two or more gum quadrants Note: Benefits are provided for the dental services listed above only when the Member has a serious medical condition that makes it essential that he or she be admitted to a general hospital as an inpatient or to a surgical day care unit or ambulatory surgical facility as an outpatient in order for the dental care to be performed safely. Serious medical conditions include, but are not limited to, hemophilia and heart disease.	$300 Copayment per admission if inpatient services are required. $100 Copayment per admission if Surgical Day Care Services are required.	20% of the Reasonable Charge* after the Deductible has been met.

*The definition of Reasonable Charge is included at the end of this table.

Service	Member Cost	
	In-Network (Participating Providers)	Out-of-Network (Non-Participating Providers)
Home Health Care Services		
▪ Home care services ▪ Intermittent skilled nursing care No Member Cost or benefit limit applies to durable medical equipment, physical therapy or occupational therapy received as part of authorized home health care.	No Member Cost.	20% of the Reasonable Charge* after the Deductible has been met.
Diabetes Equipment and Supplies		
▪ Therapeutic molded shoes and inserts, dosage gauges, injectors, lancet devices, voice synthesizers and visual magnifying aids	No Member Cost.	20% of the Reasonable Charge* after the Deductible has been met.
▪ Blood glucose monitors, insulin pumps and supplies and infusion devices	No Member Cost.	
▪ Insulin, insulin syringes, insulin pens with insulin, lancets, oral agents for controlling blood sugar, blood test strips, and glucose, ketone and urine test strips	30-day supply at a retail pharmacy • $10 Copayment for Tier 1 items • $20 Copayment for Tier 2 items • $40 Copayment for Tier 3 items 90-day supply through mail-order pharmacy • $20 Copayment for Tier 1 items • $40 Copayment for Tier 2 items • $90 Copayment for Tier 3 items	
Durable Medical and Prosthetic Equipment		
Durable medical and prosthetic equipment coverage includes, but is not limited to: ▪ Durable medical equipment ▪ Prosthetic devices ▪ Breast prostheses, including replacements and mastectomy bras ▪ Ostomy supplies ▪ Wigs - up to a limit of $350 per calendar year when needed as a result of any form of cancer or leukemia, alopecia areata, alopecia totalis or permanent hair loss due to injury ▪ Oxygen and respiratory equipment	No Member Cost.	20% of the Reasonable Charge* after the Deductible has been met.

*The definition of Reasonable Charge is included at the end of this table.

Service	Member Cost	
	In-Network (Participating Providers)	Out-of-Network (Non-Participating Providers)
Other Health Services		
▪ Cardiac rehabilitation	Tier 1: $15 Copayment per visit. Tier 2: $25 Copayment per visit. Tier 3: $35 Copayment per visit.	20% of the Reasonable Charge* after the Deductible has been met.
▪ Dialysis ▪ Speech-language and hearing services, including therapy ▪ Ambulance services (Out-of-Network ambulance services in an emergency will be covered at the In-Network benefit level) ▪ Low protein foods ($2,500 per Member per calendar year) ▪ State mandated formulas	No Member Cost.	20% of the Reasonable Charge* after the Deductible has been met.
▪ Chiropractic services - up to 20 visits per calendar year ▪ Early intervention services - up to a maximum of $5,200 per Member per calendar year and a lifetime maximum of $15,600 ▪ Physical and occupational therapies - up to 90 consecutive days per illness or injury	Tier 1: $15 Copayment per visit.	20% of the Reasonable Charge* after the Deductible has been met.
▪ Second opinion	Tier 1: $15 Copayment per visit. Tier 2: $25 Copayment per visit. Tier 3: $35 Copayment per visit.	20% of the Reasonable Charge* after the Deductible has been met.
▪ Hearing aids - every 2 calendar years	Covered in full for the first $500. 20% Coinsurance of the next $1,500, up to a maximum benefit of $1,700 every 2 calendar years.	
▪ House calls	Tier 1: $15 Copayment per visit. Tier 2: $25 Copayment per visit. Tier 3: $35 Copayment per visit.	20% of the Reasonable Charge* after the Deductible has been met.

Service	Member Cost	
	In-Network (Participating Providers)	Out-of-Network (Non-Participating Providers)
Other Health Services (Continued)		
▪ Hospice services	No Member Cost for inpatient or outpatient hospice care. $300 Copayment per admission if Inpatient Acute Hospital Services are required.	20% of the Reasonable Charge* after the Deductible has been met.
▪ Vision hardware (such as eyeglasses or contact lenses) only for certain special conditions (please see your Benefit Handbook for details on your coverage)	No Member Cost up to the benefit limit.	20% of the Reasonable Charge* after the Deductible has been met. (only covered up to the benefit limit as described in the *Handbook*.)
▪ Prescription Drug Coverage (Please see the Prescription Drug Brochure for more information on your prescription drug coverage.)	30-day supply at a retail pharmacy • $10 Copayment for Tier 1 items • $20 Copayment for Tier 2 items • $40 Copayment for Tier 3 items 90-day supply through mail-order pharmacy • $20 Copayment for Tier 1 items • $40 Copayment for Tier 2 items • $90 Copayment for Tier 3 items	

*Reasonable Charge - In the judgment of HPHC, an amount that is consistent with the normal range of charges by health care providers for the same, or similar, products or services in the geographical area where the product or service was provided to a Member. If HPHC cannot reasonably determine the normal range of charges where the products or services were provided, HPHC will utilize the normal range of charges in Boston, Massachusetts. The Reasonable Charge is the maximum amount that the Plan will pay for Covered Services.

Special Enrollment Rights

If an employee declines enrollment for him/herself and his or her dependents (including a spouse) because of other health insurance coverage, the employee may be able to enroll in this Plan in the future along with his or her dependents, provided that enrollment is requested within 30 days after other coverage ends. In addition, if the employee has a new dependent as a result of marriage, birth, adoption or placement for adoption, the employee may be able to enroll along with his or her dependents, provided that enrollment is requested within 30 days after the marriage, birth, adoption or placement for adoption.

Required Approvals When Using Non-Participating Providers

Hospital Admissions

Members are responsible for obtaining approval from HPHC before any hospital admission (including Day Surgery and day hospitalization for psychiatric or substance abuse services) occurs when either the doctor or facility is a Non-Participating Provider. If approval of the admission is not received, the Member is responsible for the first $500 of the Reasonable Charge for medical care and the first $200 of the Reasonable Charge for mental health substance abuse services. This payment does not count toward the Deductible or the Out-of-Pocket Maximum amount.

Specialized Procedures and Services

When using Non-Participating Providers it is the Member's responsibility to obtain approval from HPHC for certain procedures and services before any costs are incurred. If approval is not obtained, the Member is responsible for the first $500 of the Reasonable Charge for medical services and the first $200 of the Reasonable Charge for mental health and substance abuse services. These payments do not count toward the Deductible or the Out-of-Pocket Maximum amount.

Please refer to Section A.6 of the Benefit Handbook (titled "Prior Approval Program") for a detailed listing of the procedures and services for which this requirement applies.

48 Hour Emergency Notification

In cases of an emergency hospital admission to a Non-Participating Provider, HPHC must be notified within 48 hours of the admission or as soon as you can. If notification is not received, the Member is responsible for the first $500 of the eligible expense. The $500 payment does not count toward the Deductible or the Out-of-Pocket Maximum limit.

Exclusions

- Cosmetic procedures, except as described in your Benefit Handbook for post-mastectomy or reconstructive surgery
- Sclerotherapy for the treatment of spider veins
- Commercial diet plans or weight loss programs and any services in connection with such plans or programs
- Gender reassignment surgery, including related drugs or procedures
- Services that are not Medically Necessary, including a service, supply or medication if there is a less intensive level of service, supply or medication or more cost-effective alternative which can be safely and effectively provided, or if the service, supply or medication can be safely and effectively provided to you in a less intensive setting
- Any products or services, including, but not limited to drugs, devices, treatments, procedures, and diagnostic tests, which are Experimental, Unproven, or Investigational
- Refractive eye surgery, including laser surgery and orthokeratology, for correction of myopia, hyperopia and astigmatism
- Transportation other than by ambulance
- Costs for any services for which you are entitled to treatment at government expense, including military service-connected disabilities
- Costs for services covered by workers' compensation, third party liability, other insurance coverage or an employer under state or federal law
- Hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy
- Routine foot care, biofeedback, pain management programs, sports medicine clinics, hypnotherapy, psychoanalysis, services by a personal trainer, cognitive rehabilitation programs, and cognitive retraining programs
- Any treatment with crystals
- Blood and blood products
- Educational services and testing. No benefits are provided: (1) for educational services intended to enhance educational achievement; (2) to resolve problems of school performance; or (3) to treat learning disabilities
- Sensory integrative praxis tests
- Physical examinations for insurance, licensing or employment
- Rest or custodial care
- Personal comfort or convenience items (including telephone and television charges), exercise equipment, wigs (except as required by state law and specifically covered in this Schedule of Benefits), and repair or replacement of durable medical equipment or prosthetic devices as a result of loss, negligence, willful damage or theft
- Health resorts, recreational programs, camps, wilderness programs, outdoor skills programs, relaxation or lifestyle programs, including any services provided in conjunction with, or as part of such types of programs
- Group diabetes training or educational programs or camps
- Unless otherwise specified in the *Schedule of Benefits* or *Benefit Handbook*, the Plan does not cover food or nutritional supplements, including FDA-approved medical foods obtained by prescription
- Non-durable medical equipment, unless used as part of the treatment at a medical facility or as part of approved home health care services
- Reversal of voluntary sterilization (including procedures necessary for conception as a result of voluntary sterilization)
- Any form of surrogacy
- Infertility treatment for Members who are not medically infertile
- Devices or special equipment needed for sports or occupational purposes
- Devices or procedures intended to reduce snoring, including but not limited to, laser-assisted uvulopalatoplasty, somnoplasty, and snore guards
- Services for which no charge would be made in the absence of insurance
- Services after termination of membership
- Services for non-Members
- Services or supplies given to you by: (1) anyone related to you by blood, marriage or adoption or (2) anyone who ordinarily lives with you
- Services for which no coverage is provided in the Benefit Handbook, Schedule of Benefits or Prescription Drug Brochure
- Any home adaptations, including, but not limited to, home improvements and home adaptation equipment
- Vocational rehabilitation or vocational evaluations on job adaptability, job placement or therapy to restore function for a specific occupation
- Care outside the scope of standard chiropractic practice, including, but not limited to, surgery, prescription or dispensing of drugs or medications,

internal examinations, obstetrical practice or treatment of infections and diagnostic testing for chiropractic care other than an initial x-ray

- Charges for any products or services, including, but not limited to, professional fees, medical equipment, drugs and hospital or other facility charges that are related to any care that is not a covered service under your Handbook
- Services for a newborn who has not been enrolled as a Member, other than nursery charges for routine services provided to a healthy newborn
- Charges for missed appointments
- Acupuncture, aromatherapy and alternative medicine
- Planned home births
- Mental health services that are (1) provided to Members who are confined or committed to a jail, house of correction, prison or custodial facility of the Department of Youth Services or (2) provided by the Department of Mental Health
- All charges over the semi-private room rate, except when a private room is Medically Necessary
- Hospital charges after the date of discharge
- Pre-implantation genetic diagnosis
- A provider's charge to file a claim or to transcribe or copy your medical records
- Any service or supply furnished along with a non-covered service
- Taxes or assessments on services or supplies
- Preventive dental care
- Dental services, except the specific dental services listed in your Benefit Handbook and this Schedule of Benefits. Restorative, periodontal, orthodontic, endodontic, prosthodontic and dental services for temporomandibular joint dysfunction (TMD) are not covered. Removal of impacted teeth to prepare for or support orthodontic, prosthodontic or periodontal procedures; dental fillings; crowns; gum care, including gum surgery; braces; root canals; bridges and bonding are not covered.
- Dentures
- Eyeglasses, contact lenses and fittings, except as listed in your Benefit Handbook and this Schedule of Benefits
- Foot orthotics, except for the treatment of severe diabetic foot disease